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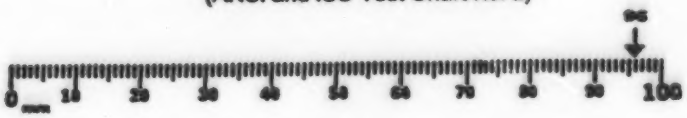


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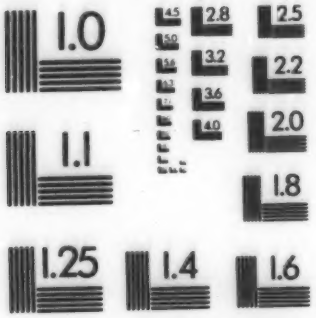


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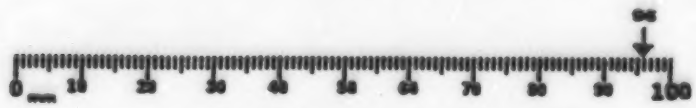


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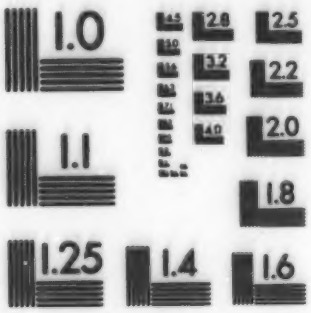


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# Adoption Questionnaire Reference Guide

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# Introduction

This guide is designed to help you fill out the adoption questionnaire as accurately and completely as possible. It presents basic information and a brief description of each section of the questionnaire.

The questionnaire is the first step of the adoption application process with the Ministry of Children and Family Development. It gives you an opportunity to identify the background factors and special needs of the child or children you wish to adopt and it helps the ministry determine when to begin an adoption home study based on the information provided in the questionnaire.

The *Adoption Act* of British Columbia governs the placement of children with adoptive families. Children become available for adoption through the Ministry of Children and Family Development either by the voluntary consent of their birth parents or through a permanent wardship order. Children available for adoption through the ministry include:

**Children with Special Needs**

- children who are part of a sibling group of two, three or more;
- children whose genetic background includes schizophrenia, mood disorders or personality disorder;
- children diagnosed with a mental disability or Down's Syndrome or whose genetic background suggests a risk of mental disability;
- children whose future health cannot be predicted because of prenatal or birth trauma or other factors (i.e. use of drugs and alcohol during pregnancy);
- children diagnosed with Neonatal Abstinence Syndrome, Fetal Alcohol Syndrome or Fetal Alcohol Effects;
- children who have intellectual and/or physical developmental delays;
- children who have serious health problems or are at risk for developing them;
- children who have or who are at risk of developing learning disabilities;
- children who have experienced physical, sexual and/or emotional abuse or neglect; and/or
- children who exhibit significant emotional and/or behavioural problems.

*Children available for adoption through the ministry may have multiple special needs related to any of the above factors.*

It is highly recommended that applicants who are planning to adopt a child or children with special needs familiarize themselves through education and preparation by:

1. Consulting with their social worker, physicians, geneticists, child and family therapists and
2. Contacting adoption resources such as the Adoptive Families Association of B.C., the Society for Special Needs Adoptive Parents, and the FAS/FAE Support Network.

## SECTION A

### Type of Application

1. If you are applying to adopt a child or children who are available for adoption in the Province of B.C.
2. If you are seeking to adopt a child or children for which you have been providing foster care.
3. If you are applying to adopt a specific child or children in the care of the ministry.

## SECTION B

### Sex of Child

If you have a definite preference for a male or female child, check only one category. Check "either" if you would accept either a male or female child.

## SECTION C

### Number of Children

Adoptive applicants who wish to adopt one child, twins or sibling groups can check any of the categories listed.

## SECTION D

### Age of Children

Children available for adoption are "matched" with adoptive parents' requests as specified on the adoption questionnaire, including age.

Indicate in months or years (from 0-18 years), the age of the child/children you wish to adopt. Do not use words such as newborn, infant, any age, adolescent, two years younger than our youngest, etc.

## SECTION E

### Birth Family Information Not Available

While the birth mother's information may be fairly complete, information on the birth father may be very limited or non-existent. In the case of a child who has been abandoned, no information will be available on either parent. The risk with any of these unknowns is that the genetic factors in the family background might affect the child now, or in the future.

Each box you check identifies that you are willing to accept the unavailability of that information.

## SECTION F

**Child Conceived as a Result of:**

1. SEXUAL ASSAULT

   Even when the birth father is known, any information about him is generally quite limited. This means that important genetic information will not be available. As adopting parents you need to be aware of your feelings concerning sexual assault as this may affect your feelings about or attitude towards the child.

2. INCEST

   This refers to a child conceived within a relationship between two people who are blood-related such as father and daughter. While a child conceived from an incestuous relationship will have a higher than normal chance of being affected by a genetic disorder, it is important to stress that the child may also be perfectly healthy. If genetic concerns do exist, they may not be identifiable at birth. A genetic assessment can be done, but it is not possible to rule out all risks. As adopting parents, you need to be aware of your feelings and attitudes about incest.

## SECTION G

### Child was Born Prematurely

1. LOW RISK

   An infant who has one or more of the following:
   - > less than one month premature;
   - > birth weight over four pounds (2.5 kg);
   - > did not experience infant trauma or illness such as convulsions or respiratory problems;
   - > is feeding well; and
   - > has a family history which does not indicate any risk of physical or intellectual developmental delays or illnesses.

2. HIGH RISK

   An infant who has one or more of the following:
   - > several weeks premature;
   - > birth weight under four pounds (2.5 kg);
   - > requires extensive medical intervention that includes life supports and a lengthy hospital stay; and
   - > has a family history which indicates risks of physical or intellectual developmental delays or illness.

To facilitate bonding, adopting parents are usually asked to become involved with the infant's care if the infant will be in hospital for a long time.

## SECTION H

### Genetic Factors and Risks

The human body is composed of billions of cells with each having a nucleus that contains chromosomes. Each human cell normally has 46 chromosomes. Chromosomes are composed of genes. In fact, our bodies have over 100,000 chromosomes which control the body's appearance and functioning. Genes are the basic units of inheritance that transmit traits from parent to child during conception. Everyone has genes that have the potential to cause illness or disabilities in their children.

The implications of, and risks related to genetic conditions can have a major impact on the lives of adopted children and their adoptive families. It is important for adoptive parents to obtain as much information as possible about the medical, social and psychological history of the child they adopt. Genetic family histories can help potential adoptive parents make informed decisions about their ability to parent a child who has certain genetic concerns or risks, and to anticipate the child's special needs.

Information about a genetic condition can facilitate appropriate intervention, treatment, and prevention that could improve the quality and length of a child's life. Genetic research has made many advances in our knowledge about genetic disorders and in developing genetic services that are beneficial to children and families affected by or at risk for genetic disorders.

"Genetic Disorders" refer to a wide range of conditions with diverse causes. More than 4,000 inherited diseases have been identified. In general, genetic disorders are described as permanent, complex and lifelong familial conditions. It is incorrect to equate genetic

conditions with inherited disorders. Although all inherited disorders are genetic, not all genetic disorders are inherited. Birth defects can be caused by environmental conditions, such as chemicals and other contaminants.

There are four types of genetic disorders: single gene, chromosomal, multifactorial and environmental agents.

1. Single gene disorders are associated with a single defective gene, i.e., cystic fibrosis, neurofibromatosis, sickle cell disease and hemophilia.
2. Chromosomal disorders occur as a result of a change in the number or structure of chromosomes i.e., Down's syndrome.
3. Multifactorial disorders are caused by the interaction of specific genes with environmental factors. Height and weight are everyday examples of multifactorial inheritance. Common examples of multifactorial disorders include Spina Bifida, cleft lip or palate, club foot, diabetes mellitus, congenital heart disease, some cancers and mental disabilities. Some psychiatric conditions such as schizophrenia may be related to multifactorial inheritance.
4. Certain genetic disorders are caused by specific environmental agents that are potentially harmful when exposure occurs during prenatal development. Examples include sexually transmitted diseases, infections, maternal biochemical factors and nuclear radiation.

Section H identifies seven conditions that have genetic components. Further information regarding allergies, asthma, diabetes and epilepsy can be found in Section L. Information about mental disabilities is in Section J.

kids can't
wait to have
a family

*Schizophrenia*

Researchers have developed a complex, multifaceted view of schizophrenia, which reflects a wide range of approaches and theoretical conceptions. There is much controversy about the causes of schizophrenia, which are still largely unknown. Research evidence, however, does suggest that genetic factors play an important part in the development of schizophrenia, which is a psychiatric condition. How schizophrenia is genetically transmitted is not understood.

The occurrence of schizophrenia in the general population is about one percent. There is an increased prevalence of this condition in biologic relatives of a person with schizophrenia. Individuals who are raised in close proximity with a person who has schizophrenia, but without a blood relationship, show no more risk of schizophrenia than the general population.

The onset of schizophrenia is usually during adolescence or early adulthood. Schizophrenia involves disturbances of several psychological processes in varying intensity at different stages of the condition. It is a thought disorder which includes delusions and hallucinations, usually auditory in nature. Difficulties with interpersonal relationships arise because of social withdrawal and emotional detachment. Schizophrenia can be a severe chronic psychiatric condition which markedly decreases a person's ability to function on a number of levels and affects their work, interpersonal relationships, self-care and family life. A person who develops schizophrenia may need periodic psychiatric hospitalization, stabilizing medications and specialized community programs to aid them and help improve their quality of life.

*Mood Disorders and Personality Disorder*

There are several different types of psychological disorders with a possible genetic cause, but the two most typically identified in the backgrounds of the children for whom adoption is planned by the ministry are mood disorders and personality disorder.

Mood disorders include two types, Major Depression and Bipolar Disorder. Major Depression includes the conditions Melancholia, Depression with Psychotic Symptoms, Seasonal Mood Disorders, Atypical Depression and Dysthmia. Bipolar Disorder includes the subtypes manic and hypomanic, with or without depression. The occurrence in the general population of Major Depression is between five and 20 percent, while the occurrence of Bipolar Disorder is one to two percent. Parents, children or siblings of a person with Major Depression have two times the risk of having Major Depression as does the general population. Parents, children or siblings of a person with Bipolar Disorder have four to 25 times the risk of having Bipolar Disorder or Major Depression as does the general population.

A person with depression experiences hopelessness and lethargy while a person in a manic state can be hyperactive, wildly optimistic and impulsive. A person with Bipolar Disorder may alternate between the two states or may only display manic or hypomanic episodes.

Personality disorder is characterized by inflexible and enduring behaviour patterns which impair one's social functioning.

These disorders can present a wide range of minor to severe dysfunctions. For someone considering a child where one or both of the birth parents have one of these or other types of psychological disorders, it would be important to research factors such as degree of genetic risk, age of onset and management through medication and other means.

## SECTION 1

**Prenatal Drug and Alcohol History or Diagnosis:**

Effects of drugs and alcohol on infants vary greatly depending on the types and the amounts of drugs used, the stages of pregnancy in which drug or alcohol use occurred, the frequency of that use, the genetic make up of the mother, and how psycho-social and other elements such as diet, disease, poverty, housing, experience with violence, and prenatal care affected the mother. Because many infants have been exposed to a combination of various drugs including nicotine and alcohol, and the information regarding the quantity and timing of use is often unreliable, predicting a child's future needs is very difficult. All children are not affected in the same way, and predicting future problems which children may experience is impossible.

These children may benefit from early diagnosis and support, and continuing medical and developmental surveillance. It is known that they progress better in stable, consistent and loving homes.

1. DRUG EXPOSURE-KNOWN LIMITED USE
   Children whose birth mothers used limited amounts of certain prescription and/or illegal drugs during the first three months of pregnancy, or small amounts on limited occasions during a later stage of pregnancy often appear healthy at birth. Long term effects of this usage is unknown. There are no known indicators which will allow a physician to predict future effects. These children require ongoing developmental and medical surveillance, and may do very well.

## 2. DRUG EXPOSURE-PROLONGED USE

**This refers to the category formerly described as Neonatal Abstinence Syndrome (NAS) and includes prolonged exposure to the following drugs before birth.**

*Opiates*

NAS is the medical diagnosis given to a child who shows medical and behavioural signs of withdrawal from opiates such as heroin and methadone. These signs are usually manifested between birth and 14 days of life. As infants, these children show signs of irritability of the central nervous system and can be difficult to console. During the next six months of life they may be unable to regulate sleep and hunger patterns. There is no way to predict whether a child experiencing these problems will develop any difficulties as they mature, and there should be ongoing medical and developmental surveillance. It is known that many children respond very well to patience and consistency and may develop within a normal range.

*Cocaine or Crack*

Infants whose mothers used cocaine or crack are often born prematurely or with low birth weights, and are usually assessed for birth defects of the urinary tract, heart or brain. They also have a higher risk of Sudden Infant Death Syndrome (SIDS) than non-exposed infants, may need medical attention for some acute or chronic conditions, and many be at risk for developmental delays and learning disabilities. Some studies indicate that with careful protections from over-stimulation and with a nurturing and structured home and learning environment which emphasizes stable and predictable routines, many cocaine-exposed children respond to their caregivers and develop within a normal range. Each child must be assessed individually because drug exposure in itself is not a reliable predictor of future health or long term problems.

*Other Prescription or Non Prescription Drugs*

Depending on the amount used, children exposed to other drugs may require initial intervention for withdrawal when the symptoms appear, usually in the first two weeks of life. Medical professionals indicate that for the majority of children exposed to a number of drugs, discerning which drugs were used and the quantities of each is difficult. Studies of long term effects of other drugs are not conclusive and professionals are advising that each child should be assessed on an ongoing individual basis.

*Characteristics of Children Affected by Prolonged Prenatal Drug Use*

Symptoms of withdrawal from drugs may not necessarily be diagnosed at birth. However some of these children may be at risk for effects later in life. Withdrawal symptoms can be, but may not necessarily be a predictor of later effects.

Effects may include sleep disturbances, difficulty with attention span, delayed speech and language development, difficulties understanding and using information and poor impulse control. These children may find making and keeping friends a challenge. Some children may have weak muscle tone and problems with movement and co-ordination. Some of these children do not understand that their actions lead to consequences, and some may have difficulty making sudden changes or choices, or making transitions from one activity to another.

3. ALCOHOL EXPOSED

An infant whose birth mother used an undetermined amount of alcohol during the pregnancy can appear healthy at birth, but remain at risk for developing effects later in life. It is impossible to predict future effects because of the many variables, including how much alcohol was consumed per day, the stage of pregnancy during which it was consumed, the number of days in which alcohol was consumed during the pregnancy and when the alcohol consumption ended. Not all children are equally affected by exposure to small or large amounts of alcohol, and it is important to assess each child's experience and plan individually for each child. There is no information about the alcohol consumption of the mother or the symptoms of the child at birth that would indicate that a child might be mildly affected or not affected in later years.

4. FETAL ALCOHOL EFFECT (FAE) AND FETAL ALCOHOL SYNDROME (FAS)

Fetal Alcohol Effect (FAE) is identified when it is known that a child has been exposed to alcohol before birth and has met any two of the three criteria for diagnosing Fetal Alcohol Syndrome (FAS). Although these children may have fewer physical effects, problems of the central nervous system may be just as severe as for the child with FAS.

FAS is a disorder which is a result of the consumption of a significant amount of alcohol during pregnancy. The effects of this alcohol use on a child are permanent and change as a child matures into adolescence and adulthood. There is no conclusive information available to determine how much alcohol consumed at which stage of a pregnancy will

4. FETAL ALCOHOL EFFECT (FAE) AND FETAL ALCOHOL SYNDROME (FAS) *(continued)*

predict a diagnosis of FAS. Other factors which are thought to contribute to the effects of prenatal alcohol exposure include the mother's prenatal diet and health and her genetic make up which determines how she metabolizes alcohol. There is no known safe amount of alcohol consumption during pregnancy.

To be diagnosed with FAS, a child must be exposed before birth to alcohol and meet all of the following three criteria:

a) Specific facial characteristics, such as short eye slits and a smooth elongated space between the nose and lip.

b) Slow growth rates in utero and after birth.

c) Evidence of central nervous system damage. Most children will exhibit mild to severe learning disabilities in addition to behavioural and emotional problems which vary as they mature. They may have difficulty adapting to changes in conditions and circumstances. The effect of alcohol exposure in utero on the I.Q. of children can vary greatly in both FAE and FAS children, from within average range to well below.

*Characteristics of Children with FAE and FAS*

The following are a few of many general indicators of patterns which are seen in some, but not every child, depending on many factors including the health and experiences of both the child and mother. Some effects become evident at an earlier age than others.

Infants with FAS and FAE can be irritable and may have problems feeding and sleeping. They may also have some motor and speech delays.

Preschool children may continue to have motor, speech and learning delays. They often resist change in routines and can become easily frustrated. They may have little sense of risk. They benefit greatly by early diagnosis, intensive supervision and a great deal of structure.

Children ages six to twelve may need assistance with their social and learning needs which may include an inability to think abstractly and difficulty learning that their actions lead to consequences. They can be disruptive and hyperactive, and may have difficulty paying attention for long periods of time.

FAE/FAS adolescents continue to find school a challenge and need assistance with their leaning needs and social relationships. They can be impulsive and easily distracted, and may lack inhibition. They may have difficulty with critical thinking and abstract reasoning and may require personal attention at home and at school to structure learning and social environments which enhance their experience of success.

## SECTION J

### Intellectual Disabilities

This section provides general information about children awaiting adoption whose overall functioning and development is affected by Mental Development Delay, mental disability or Down's syndrome. The terms listed below are often used in educational and medical settings in diagnosing and appropriately meeting the special needs of these children. Adopting parents need to look beyond these children's limitations to see their many individual strengths and potentials. Many communities have supports and services available for families and their children with mental disabilities. They include infant development programs, family support homemakers, daycare for children with special needs, specialized school programs and respite care.

1. MENTAL DEVELOPMENTAL DELAY

   Mental Developmental Delay is when a child is achieving the normal developmental milestones, but at a later age than is normally expected. The child may be delayed in the areas of speech and language, cognition and/or social-emotional growth. Though the child is late in achieving a developmental skill, it is accomplished in a normal manner. Mental Developmental Delays can be displayed by some premature infants up to a certain age, or caused by brain or nerve damage and/or by abuse/neglect trauma.

2. MENTAL DISABILITY

   The term mental disability is used to describe significant deficits in an individual's intellectual functioning and social adaptive behaviour originating during the developmental period from birth to eighteen years. Levels of mental disability include mild, moderate and severe

deficits based on I.Q. ranges. The vast majority of people with a mental disability are in the mild range (I.Q. 50-70). Causes may include prenatal infections, birth delivery complications, childhood illness, trauma from abuse and deprivation, accidents, toxins and genetic or chromosome disorders.

Children who are mentally disabled are slow or delayed in all areas of development; i.e., thinking, speaking, motor skills, social-emotional growth and self help. These children learn and progress more slowly than others and always require assistance and repetition in accomplishing tasks. Preschoolers experience a lag in motor activities such as crawling, sitting, walking, eating and communication skills. School-age children have difficulties learning in school and utilizing intellectual skills.

3. DOWN'S SYNDROME

Down's syndrome is the term used to describe children born with an extra #21 chromosome, which causes mental disabilities and distinctive physical features. This chromosomal disorder is rarely hereditary – only in four percent of Down's syndrome cases. Down's syndrome children are slow in their physical and behavioural development, and have unique facial and bodily features. No one child has all the possible features of Down's syndrome. They can appear in a variety of combinations with no connection to the degree of mental disability. The level of mental functioning varies significantly. Extra stimulation and encouragement to learn during infancy and childhood help children with Down's syndrome develop to their fullest potential. Many of these children can be educated in the regular school system, acquiring self-care skills that will contribute

3. DOWN'S SYNDROME *(continued)*

towards independence in adulthood. Medical concerns related to Down's syndrome include congenital heart defects, gastrointestinal blockage, vision problems, hearing loss and susceptibility to respiratory infections. Despite some of the medical problems, it is important to emphasize that the majority of individuals with Down's syndrome have long and fully functional lives.

## SECTION K

### Physical Disabilities

1. DEVELOPMENTAL DELAY

A child is developmentally delayed when he/she is achieving the normal developmental milestones but at a later age than normally expected. The child may be delayed in the area of motor skills, such as rolling, sitting, crawling and walking.

2. SPINA BIFIDA

Spina Bifida is a condition where some of the vertebrae of the spinal cord are not completely formed and the spinal cord and its coverings usually protrude through the opening. Early surgical correction can help prevent infection, but cannot correct the condition. Spina Bifida is associated with a range of disabilities including physical abnormalities and learning difficulties. Sometimes a child with Spina Bifida will also have a condition called hydrocephalus. (See Section L, #7)

3. CEREBRAL PALSY

Cerebral palsy is a disorder caused by damage to the brain occurring during pregnancy, as a result of birth trauma, or resulting from early childhood disorders such as meningitis, head trauma, or poisonings. It is characterized by the inability to perform or control motor functions, and can be associated with disabilities such as speech-language disorders and seizures.

4. ORTHOPAEDIC IRREGULARITIES

a) Club Foot- an irregularity of the foot and ankle. Most commonly, the foot is positioned downward and inward. Minor problems can be corrected through exercise. More complex problems could require a cast or surgery.

b) Polydactyl- a child born with extra fingers or toes. These are removed through minor surgery.

c) Syndactylia- a fusion of the skin or bones of two or more fingers or toes which can be corrected with minor surgery.

d) Absence of a limb.

5. FACIAL IRREGULARITIES

a) Cleft lip and Palate-Cleft lip is a separation or slit in the upper lip. This condition ranges from a minor notching of the upper lip to a complete slit which extends from the edge of the lip to the nostril, and involves the bone that forms the framework for the upper gums and teeth. It may occur on one side or both. Cleft palate is a lengthwise slit in the roof of the mouth, forming one cavity for the nose and mouth. It may be minor (affecting only the back part of the roof of the mouth) or complete. This abnormality can affect the development of teeth, and also affects speech and nutrition.

b) Birth Marks/Port Wine Stain-Strawberry marks due to an overgrowth of blood vessels in a confined area. They may be found on any part of the body, may be flat or raised, and may range in colour from light red to blue/black. Some are permanent while others gradually fade away. A skin specialist should be consulted.

## SECTION L

### Medical Diagnosis

1. ALLERGIES

An allergy is a condition in which a person has an unusual reaction to substances which are ordinarily harmless. These may be taken into the body by being inhaled, swallowed or through contact with the skin. The best treatment for allergies is the complete removal of the cause or causes of the allergy from the environment of the person involved. If this is not possible, medication could alleviate symptoms. Many of the substances which cause allergies are found in food, so special diets are common.

2. ASTHMA

The word asthma is derived from the Greek word meaning "gasping". Asthma may be defined as an allergic disorder of the respiratory system in which the airway becomes temporarily constricted. An asthmatic attack is characterized by violent coughing, wheezing, shortness of breath and general difficulty in breathing. There in no known cure for asthma. However, there are measures that can be taken to control the effects, allowing the person to carry on a reasonably normal life. Some children outgrow the problem

without any particular treatment. Children showing symptoms of asthma should be treated medically at an early age to avoid permanent damage to the lungs and chest wall.

3. JUVENILE DIABETES

This is a condition in which the body does not supply enough insulin. When the pancreas does not produce a sufficient supply of insulin, the cells cannot use the sugar in food, and the liver and muscles cannot store it. Treatment for diabetes includes insulin injections and special diet requirements. Children with diabetes will have to take insulin for the rest of their lives.

4. EPILEPSY

Epilepsy is a disorder of the nervous system. The person with epilepsy has a tendency to have seizures, caused by erratic, uncontrolled electrical discharges in the brain. The three most common types of epilepsy are Grand Mal Seizures, Petit Mal Seizures and Psychomotor Seizures. Most epileptic seizures can be controlled by anti-convulsive drugs. These drugs usually allow the person with epilepsy to lead a normal, productive life.

5. ATTENTION DEFICIT DISORDER (ADD)

Attention Deficit Disorder (ADD) requires intensive and long term treatment. The symptoms of this disorder include a short attention span, impulsive behaviour, distractibility and hyperactivity. The diagnosis of ADD relies on the presence of this cluster of symptoms and the exclusion of other causes of similar behaviours. The child's behaviour usually results in serious disturbances in his/her relationship with parents, teachers, peers and siblings as well as in

5. ATTENTION DEFICIT DISORDER (ADD) *(cont'd)*

academic problems. ADD is not a learning disability, but if untreated it may seriously hamper a child's ability to learn. Children with ADD often exhibit defiant and non-compliant behaviour towards adults, and verbal and physical aggression towards peers and siblings. Many children with ADD also have learning disabilities.

6. HEART DEFECT

Some heart defects present at the time of the child's birth may be self-correcting, while others require surgery and annual monitoring. For the most part, these children lead healthy, normal lives. In serious cases, a child's heart condition may require extensive medical intervention and daily monitoring by parents over a number of years.

7. HYDROCEPHALUS

This condition, usually diagnosed at birth or shortly thereafter, is characterized by the abnormal accumulation of spinal fluid within the brain. The accumulation of fluid leads to an increase in head size which causes pressure against the brain tissue. This pressure has the potential to cause permanent brain damage. Early treatment, which involves implanting a shunt to drain fluid from the brain, and good medical management, can reduce or eliminate the risk of brain damage.

8. FAILURE TO THRIVE

This term is used to describe infants and children who fail to gain weight or even lose weight without any apparent cause. "Failure to thrive" is considered to be a form of "infant depression" caused by emotional deprivation or environmental disruptions.

9. SHORT LIFE EXPECTANCY

This applies to children whose diagnosed medical condition means that their life expectancy is short.

10. HIV POSITIVE

The Human Immunodeficiency Virus, or HIV, is the agent responsible for causing the disease AIDS (Acquired Immune Deficiency Syndrome). Infants born to HIV positive mothers will be HIV positive at birth. Because it take babies 15-25 months to develop their own immune systems, these children should be tested every six months for the first two years of their lives. If, at the end of that time, these children continue to test HIV positive, they have been infected and will likely develop symptoms of AIDS during their early years of life. If they test HIV negative, they have not been infected and have no further risk of becoming HIV positive from the pre-natal contact.

Approximately 50 percent of infants who are HIV positive will experience some developmental delay, or loss of previous developmental achievements. These are expected to worsen as the disease progresses. They may also lose muscle tone and the ability to walk without support. Many children experience speech problems, such as poor pronunciation. Accompanying these problems will be other signs of symptomatic HIV infection, such as chronic fever, diarrhea, poor growth, and various bacterial infections. The life expectancy for children born with AIDS is increasing with the discovery of new treatments.

11. FEEDING/SPECIAL DIET ADMINISTRATION

Some children have medical conditions which require them to be tube-fed. These are not life threatening health concerns, but are time-consuming daily administrations for adoptive parents. Special diets, which can be costly, can require separate preparation from the family meal and constant monitoring.

## SECTION M

### Sensory Loss

1. HEARING IMPAIRED

This refers to the child who is deaf, or in whom the sense of hearing is non-functional. Primary communication would need to occur through signing.

2. VISION IMPAIRED

This refers to the child who has a severe vision impairment and is considered blind.

## SECTION N

### Learning Disabilities (LD)

Learning Disabilities (LD) is the name given to a collection of learning problems that children may have, especially when mental disability has been ruled out. LD children may be hyperactive, have perceptual-motor problems, attention problems, or disorders of memory and conceptual thinking. There is no agreement among the experts on the cause(s) of LD or its treatment.

1. READING/WRITING

Reading disabilities are by far the most common form of learning disabilities. Since reading is the first skill in the development of the language arts, reading problems temporarily precede spelling and written expression problems. A child with language arts problems often has difficulties with handwriting and arithmetic as well.

2. ORAL LANGUAGE OR SPEECH IMPAIRMENT

Speech impairment may include difficulty in producing speech sounds, maintaining speech rhythm, or controlling voice production. Problems in producing speech sounds are known as articulation disorders and may be characterized by omissions, substitutions, distortions or additions of speech sounds. Causes may be functional, such as having poor speech models, or organic, such as having a significant hearing loss. Problems in maintaining speech rhythm include stuttering and cluttering. There are many theories as to their causes. Voice disorders are characterized by a significant deviation in voice quality, pitch, intensity or flexibility from the societal standard. All of these problems should be referred to a speech therapist for evaluation and correction.

## SECTION O

### Experiences of the Child

The Ministry of Children and Family Development is involved in adoption planning for children who have experienced physical, sexual and emotional abuse and/or physical and emotional neglect. Some of these children may have been separated from their birth families, as well as from relatives and other significant people in their lives. Older children may experience a series of separations from different caregivers before they are placed with their adoptive family. The combination of traumatic experiences caused by abuse, and the loss of/or separation from familiar and significant people, contribute to a child's vulnerability in adoption. Adoptive applicants who are planning to adopt a child from an abusive background need to have a realistic idea of what the child may have been through. The following broad discussions of the background factors which a child may have experienced are intended to give adoptive applicants some general information and exposure to the types of preplacement histories of many of the children for whom the ministry plans adoption.

1. SEXUAL ABUSE

Sexual abuse is inappropriate sexual behaviour towards children. Sexual abuse of children most frequently involves adults, but can also involve older children, siblings or youth. Mutual consensual sexual exploration between children or youth of similar ages is not considered sexual abuse.

Sexual abuse includes sexual touching, sexual intercourse, sexual exploitation, sexual assault and incest. Children are dependent upon their family unit for emotional and physical security. The sexual abuse of children exploits children's needs for affection and approval, and their natural sexuality. The large majority of children who are sexually abused are victims of someone known to them. Children who have been sexually abused will be affected physically, developmentally and psychologically. Child victims of sexual abuse are at increased risk for sexual abuse by others because of their earlier experiences and emotional vulnerability, and usually need therapeutic intervention to alleviate their trauma.

2. PHYSICAL ABUSE

Physical abuse is the infliction of physical force, that is non-accidental and beyond reasonable discipline upon a child. Physical injuries inflicted on children include: bruises, burns, broken bones and/or multiple injuries.

3. EMOTIONAL ABUSE

Emotional abuse is the chronically abusive behaviour by adults that injures the intellectual, psychological and emotional capacity of the child. This abuse can inhibit a child's ability to develop into an emotionally healthy adult.

4. NEGLECT

Child neglect is the gross lack of attention to the physical and/or emotional needs of a child by their birth parents or caregivers. Physical neglect is the failure to provide a child with basic physical needs: food, clothing, shelter, safety, supervision, education and medical attention.

4. NEGLECT *(continued)*

Abandonment of a child is also a form of neglect by an adult caregiver. Emotional neglect is the gross lack of attention to a child's emotional and social needs. Overall neglect can cause mental and physical developmental delays, failure to thrive, attachment issues, malnourishment, medical concerns and emotional/behaviour disturbances.

5. DETRIMENTAL PARENTING

Children whose parents are substance abusers (i.e. drugs or alcohol), or who are severely disabled because of mental illness or mental disability, experience higher than usual levels of stress in their families. These factors contribute to family dysfunction where the children may be at risk for abuse, neglect and a chronic chaotic lifestyle. Children may witness violence and/or inappropriate sexual behaviour in the family home. The parents' disability significantly interferes with their parental responsibility to meet the needs of their children and to provide a physically and emotionally stable and secure environment. These parents may be unaware, disinterested, or incapable of dealing with the effects of their circumstances on their children. Often children raised by these parents develop survival behaviours in order to cope with their stressful family environment. For example, the child may take on the parenting role for running the household and caring for younger siblings. The child's survival behaviours can create conflict for them and their adoptive parents as they adjust to traditional family roles and expectations.

## 6. MULTIPLE CAREGIVERS/ATTACHMENT ISSUES

Attachment and separation are significant issues that affect the majority of children in the ministry's care who await adoption. For many of these children, the normal developmental attachment process has been disrupted by separation from parents and/or caregivers, often several times. For these children, their attachments are problematic, or their primary attachments have been affected by abuse and neglect.

Separation from parents or caregivers to whom they are attached is traumatic for children. They may experience a range of intense feelings in relation to their individual circumstances. Many factors can influence a child's reaction to separation. These include the nature of the child's attachment to their caregivers, the circumstances of the separation, the environment they are leaving, and the child's perception of the reason for the separation. Abrupt separations for children create grief and loss issues that can, if unresolved, interfere with new attachments. Each new placement has an element of uncertainty for a child who has experienced many placements. This contributes to the child's stress and anxiety, further inhibits trust in others when forming new relationships and inhibits development of self reliance.

Some infants and children who have been severely neglected and abused have never formed primary attachments. These children have great difficulty in developing and maintaining relationships. Having received little love, they in turn have trouble giving and receiving it.

## SECTION P

### Emotional/Behavioural Characteristics which a Child May Exhibit

In this section, you are asked to consider some of the emotional and behavioural characteristics typical of children who have special needs due to the background experiences described in Section O. To summarize, these children have been traumatized by separations causing significant losses, multiple homes and caregivers, sexual, physical and emotional abuse, physical and emotional neglect, and/or failure to experience a permanent, trusting relationship with an adult. Children who experience trauma through abuse and separations react in different ways. These reactions may be displayed through behaviours such as lying, stealing, temper tantrums, bed-wetting, soiling, nightmares, aggression, hyperactivity, destructiveness, withdrawal, profound dependency and inappropriate sexual behaviour. For some of the children, the behaviours listed in Section P are transitory as they adjust to the changes in their new adoptive home. For other children, these behaviours are serious and chronic. Although there are many explanations for serious behaviour problems in children, we cannot predict or say with certainty that a specific trauma results in a specific behavioural response. It is important to recognize that these "acting out" behaviours are symptoms of abuse, not the actual problem. The abused child has learned not to trust feelings or communication. Many abused children believe they are responsible for their abuse because they assume they are bad. Their own needs, values and interests have not been respected. Their behavioural reactions are often expressions of their underlying feelings of anxiety, rejection and shame. Past traumatic experiences can revisit and affect the child at different stages of development.

Some behaviours which become serious and chronic are extremely stressful for adoptive families. Parents and families all have different levels of acceptance and coping related to their expectations, lifestyles, resources and support systems. An openness to services provided by outside professional help can be both supportive and beneficial to the child and its adoptive family.

## SECTION R

### Knowledge and/or Experience with Special Needs

This section is to be completed by those adoptive applicants who are familiar with and/or have experience with specific special needs not mentioned on the questionnaire, and would consider parenting a child with these needs. Please provide a brief description of your knowledge or experience.

## SECTION S

### Openness in Adoption

Section S addresses the concept of openness in adoption with birth families and/or previous caregivers. Adoptive applicants have the opportunity to indicate on their questionnaire the types of adoption openness they would consider in the initial adoption application process. When the adoptive applicants' homestudy is requested, their social worker will explore in depth the extent of adoption openness they wish to have.

Changing social attitudes and the complex and lifelong nature of adoption have led to the recognition that there is a desire and a need for more communication and participation in the adoption

process by adoptive parents, birth parents and adoptees. Openness in adoption makes it possible for many forms of information sharing and contact to take place between adoptive parents and birth parents. The type of adoption arrangement is the choice and mutual decision of the adoptive parents and the birth parents. A range of options involving different levels of openness are available through the ministry's adoption program. These take into account the unique circumstances of each adoption and include:

1. SEMI-OPEN ADOPTION

Semi-openness in adoption is an adoption in which a variety of contacts can occur between the birth parent(s) and the adopting parent(s) for any length of time before and/or after the adoption order is granted, but does not involve an exchange of identifying information of either party.

Examples of semi-open adoption include:

Prior to adoption placement:

- a meeting or phone contact between adoptive parents and birth parents (without identification); and
- visiting the infant in hospital.

Prior to an adoption order during the probation period:

- birth parents can provide pictures and/or letters for the child;
- adoptive parents can provide progress letters about the child's development;
- birth parents are advised of the first name given to the child by the adoptive parents; and
- adoptive parents are advised of the first name given to the child at birth.

After the adoption order is granted:

> letters, gifts and photos can be exchanged through MCF or another intermediary.

## 2. FULLY DISCLOSED ADOPTION

Fully disclosed adoption includes various contacts and information sharing between adoptive parents and birth parents before and/or after the adoption order. This involves the exchange of identifying information. Examples of fully disclosed adoption include all of the options described in semi-open adoption. There is also the possibility for ongoing contact throughout the child's growing years and the child may know the identity of the birth parent(s).

Openness in adoption is increasingly becoming a part of the adoption plan for children who are separated from their families and are permanent wards in the care of the ministry. For many of these children, significant relationships and family ties have developed that cannot be overlooked. Their background and experiences are an integral part of their identity and security. In some situations, social workers may recommend direct and/or indirect contact between the adopted child, the adoptive parents and the birth parents or relatives, where it is appropriate. The degree of adoption openness would be mutually agreed upon by the adoption parties involved, and where it is desired by and in the best interests of the child.

Adoptive applicants may want to gather information about openness in adoption by talking to their ministry adoption social worker, reading the available articles and literature on open adoption, contacting adoptive parents, adoptee and birth parent organizations, or attending open adoption workshops.

## SECTION T

### Child's Racial Heritage

This section identifies the racial heritage of the children who are available for adoption in the Province of British Columbia and through the ministry's international adoption programs. Check any or all of the racial heritages of the child/children you wish to adopt. The ministry actively seeks adoptive applicants who are of the same racial and/or cultural background of the child for whom adoption is planned. The preservation of a child's racial, ethnic and cultural heritage in the adoption process is important. Ethnic and cultural continuity for a child contribute to the development of skills necessary for successful living in a multi-ethnic society.

Note: *An Aboriginal child is a child who is registered under the Indian Act (Canada) or who has a biological parent who is registered under that act, or who is under twelve years of age and has a biological parent who is of Aboriginal ancestry and considers himself or herself to be Aboriginal or who is twelve years of age or older, of Aboriginal ancestry and considers himself or herself to be Aboriginal.*